

ROCHESTER INSTITUTE OF TECHNOLOGY

Blue PPO (Pre-Medicare)

2012 Benefit Summary

The Blue PPO is available only to those who live outside the Rochester Area

GENERAL INFORMATION

Contacting the Carrier	Voice: (877) 668-7636; TTY: (585) 454-2845 Website: www.excellusbcbs.com
Coverage Effective Dates	New Employees: Coverage is effective the first of the month after date of hire: if date of hire is the first of the month, coverage will be effective on date of hire. Retirees: Coverage is effective the date you move out of the Rochester Area. Current employees: Coverage changes will be effective the date of the event (e.g., marriage - coverage effective date of marriage). Open Enrollment changes are effective January 1.
Termination of Coverage	At termination of employment coverage ends the last day of the month in which the employee terminates. At retirement, coverage may continue in one of the retiree plans. When coverage ends, an individual may elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) for up to 18 months. In such cases, individuals are responsible for paying the full monthly premium plus a 2% administrative fee, as allowed under federal law. At the end of the COBRA coverage period, an individual may elect to convert coverage to an individual policy directly with Excellus BlueCross BlueShield. Refer to the Medical Care Section of the Employee Benefits Handbook or in the Plan Summary on the HR website for more details
Premium Payments	Employee contributions for coverage are made 24 times per year for semi-monthly (salaried) and 26 times per year for bi-weekly (hourly) employees. Contributions are made on a before-tax basis - they are not subject to federal, FICA (Medicare and Social Security), and state taxes. Retiree contributions for coverage are made monthly by check to RIT's administrator.
Referral to Specialists	No referral required
Deductible, Co-Insurance, Out-of-Pocket Maximum-Medical Plan (Excellus BCBS)	Annual deductible of \$500 per member, \$500 per person for two person and \$1,500 per family per calendar year (applies to both participating and non-participating providers). Once the deductible has been paid, you will pay <ul style="list-style-type: none">• 20% of covered services for <u>participating providers</u>, and• 30% of covered services for <u>non-participating providers</u>. The annual out-of-pocket maximum is \$1,250 for individual (\$500 deductible plus \$750 co-insurance), \$2,500 for two person (\$1,000 deductible plus \$1,500 co-insurance), and \$3,750 for family (\$1,500 deductible plus \$2,250 co-insurance) (applies to both participating and non-participating providers). After this annual out of pocket maximum has been reached, the plan pays 100% of most covered services for the remainder of the calendar year.

Deductible Carry-Over-In Network

If you have not met your deductible during the calendar year and have claims for expenses during the last calendar quarter (October-December), the last quarter's expenses will be applied toward the next calendar year's deductible.

Pre-Authorization required for all inpatient admissions, home health, infusion therapy, DME over \$200, MRI, CAT scans and PET scans

Services (sorted alphabetically)

	<u>Participating</u>	<u>Non-Participating</u>
Acupuncture	Covered at 50% subject to the deductible for up to 10 visits per member per calendar year.	Covered at 50% subject to the deductible for up to 10 visits per member per calendar year.
Allergy Injections	Covered in full.	After you pay the deductible, you pay 30% and the Play pays 70%.
Allergy Tests	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.
Ambulance	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Bone Density Testing-Routine Preventive	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force http://www.healthcare.gov/center/regulations/prevention/taskforce.html .	After you pay the deductible, you pay 30% and the Play pays 70%.
Cardiac Rehabilitation	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Chemical Dependence-Inpatient	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Chemical Dependence-Outpatient	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.
Chemotherapy	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Chiropractic Services	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.

Cochlear Implants	Must be medically necessary and prior authorization is required. Covered at 80%, subject to deductible (covered under hospital inpatient and internal prosthetic).	Must be medically necessary and prior authorization is required. Covered at 70%, subject to deductible (covered under hospital inpatient and internal prosthetic).
Colonoscopy-Diagnostic	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Colonoscopy-Routine	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force (http://www.healthcare.gov/center/regulations/prevention/taskforce.html).	After you pay the deductible, you pay 30% and the Play pays 70%.
Durable Medical Equipment (DME)	You pay 20% and the plan pays 80% for standard equipment when purchased from a participating provider.	After you pay the deductible, you pay 30% and the Play pays 70% for standard equipment.
Emergency Care	\$50 copay per visit unless admitted within 24 hours.	\$50 copay per visit unless admitted within 24 hours.
Eye Exams-Diagnostic	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.
Eye Exams-Routine	\$15 copay for routine eye exams, once every 2 years.	After you pay the deductible, you pay 30% and the Play pays 70%.
Eye Wear	No coverage through medical plan. One pair of corrective lenses after cataract surgery covered in full. There is coverage under RIT's separate Vision Care Plan. Refer to that Plan Summary for details.	No coverage through medical plan. One pair of corrective lenses after cataract surgery covered in full. There is coverage under RIT's separate Vision Care Plan. Refer to that Plan Summary for details.

Health and Wellness Programs	Blue 365 is a national program that gives you exclusive access to information, discounts and savings, making it easier and more affordable to make healthy choices.	Not applicable
	<p>Fitness: save on membership, monthly fees and other services at Gold's Gym[®], Curves[®], Snap Fitness[™] and GlobalFit[™].</p> <p>Nutrition: Save on programs, products and consultations at eDiets[®], Kronos Optimal Health[®], Jenny Craig[®] and NutriSystem[®].</p> <p>Elective Procedures: save on vision products and service at Davis Vision[®], QualSight LASIK[®], LasikPlus[®] and TruVision[™].</p> <p>Hearing aids: Save on products from Beltone[™] and TruHearing.</p>	
	Explore all the health choices at www.excellusbcbs.com/Blue365 for more details.	
Hearing Evaluations-Diagnostic	\$15 copay per visit.	Covered at 70%, subject to deductible for diagnostic visit.
Hearing Evaluations-Routine	No coverage for routine care.	No coverage for routine care.
Hearing Aids	Covered for children under age 19. Maximum of \$600 per child every 3 years through participating providers.	Only available from a participating provider.
Home Care	Covered at 80%, subject to \$50 deductible for unlimited visits.	Covered at 75%, subject to \$50 deductible for unlimited visits.
Hospice	Covered at 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Hospital Services-Inpatient	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Hospital Pre-Admission Testing	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Laboratory and Pathology	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Mammogram-Diagnostic	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.

Mammogram-Preventive	Covered in full for certain ages, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force http://www.healthcare.gov/center/regulations/prevention/taskforce.html).	After you pay the deductible, you pay 30% and the Play pays 70%.
Maternity-Hospital Charges for Mother (including Delivery Room)	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Maternity-Newborn Nursery Care	Covered at 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Maternity-Prenatal and Postpartum Care	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Mental Health-Inpatient	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Mental Health-Outpatient	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.
Occupational Therapy	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.
Out of Area Coverage	With BlueCard, you have access to a provider finder 24 hours a day by calling 1-800-810-BLUE (2583).	With BlueCard, you have access to a provider finder 24 hours a day by calling 1-800-810-BLUE (2583).
Pap Smear-Diagnostic	Covered in full. Office visit copay may apply.	After you pay the deductible, you pay 30% and the Play pays 70%.
Pap Smear-Preventive	Covered in full in certain cases, according to the Grade A and Grade B recommendations from the U.S. Preventive Services Task Force http://www.healthcare.gov/center/regulations/prevention/taskforce.html).	After you pay the deductible, you pay 30% and the Play pays 70%.
Physician Visit - In Office, Diagnostic (ill or injured)	\$15 copay per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.

Physician Visit - In Office, Routine Preventive Services

Adult routine physicals covered in full once per calendar year. Routine semi-annual GYN visits, including Pap Smear covered in full. Routine mammograms, prostate cancer screenings, and bone density testing covered in full. Adult immunizations covered in full, according to American Medical Association guidelines.

Well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics guidelines.

After you pay the deductible, you pay 30% and the Plan pays 70% for adult routine physicals once per calendar year, for semi-annual GYN visits, including Pap Smear and for adult immunizations, according to American Medical Association guidelines.

Well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics guidelines.

Physical Therapy

Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, and speech therapy per member per calendar year.

Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, and speech therapy per member per calendar year.

Prescription Drug Coverage under Medical Plan

Injectible Drugs: \$20 copay for all physician administered injectible drugs including, but not limited to, chemotherapy agents and injectible contraceptives. The copay is on the injectible agent and is in addition to any other copay. Prescription drugs administered while in the hospital are covered under the hospitalization coverage.

Copay does not apply to immunizations, vaccinations and allergy serums.

Prescription drugs administered while in a doctor's office are covered under the medical plan.

Prescription Drug Coverage under RIT Prescription Drug Plan (Medco)

Local Retail Pharmacy: Short-term medications can be purchased at the local pharmacy with the 30-day applicable copay as show below. You will not have coverage for a quantity greater than a 30-day supply at the retail pharmacy. If you take maintenance medications, you will have lower copays if you purchase them through the mail order program.

Under the **Retail Refill Allowance (RRA)** program, if you fill your maintenance medications at the retail pharmacy, you will pay the 90-day mail order copay for a 30-day supply beginning with the 4th fill (but no more than the cost of the medication). RRA does not apply to acute medications (e.g., antibiotics) or medications that cannot be filled through mail order (e.g., certain controlled substances).

Mail Order Maintenance: Most maintenance medications can be purchased by mail order in up to a 90-day supply for the copays shown below. There are three categories of prescription medication with different copay amounts. **NOTE:** the 90-day supply copays are for mail order program only.

	RETAIL <u>30-day supply</u>	MAIL ORDER <u>90-day supply</u>
Tier 1: generic drugs	\$10	\$25
Tier 2: brand name preferred or formulary drugs	\$25	\$62.50
Tier 3: brand name non-preferred or non-formulary drugs	\$40	\$100

In cases of selected brand name drugs where an FDA-approved generic is available, your benefit will be based on the generic drug's cost. If you or your doctor choose the brand-name drug, you will have to pay the difference, plus any applicable copays. If your prescription does not have an approved generic substitute, your benefit will not be affected.

Prescription drugs administered while in the hospital or doctor's office will be covered under the medical plan.

Private Duty Nursing	Not covered.	Not covered.
Prostate Testing-Routine Preventive	Covered in full	After you pay the deductible, you pay 30% and the Play pays 70%.
Prosthetics & Orthopedic Braces & Supports (External)	Standard equipment covered at 80%, subject to the deductible, up to \$15,000 per member per calendar year.	Standard equipment covered at 70%, subject to the deductible, up to \$15,000 per member per calendar year.
Prosthetics (Internal)	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Radiology (MRI, CAT, X-Ray)	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.

Respiratory Therapy-	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.
Radiation Therapy	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Skilled Nursing Facility	Covered at 80%, subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered.	Covered at 70%, subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered.
Speech Therapy	Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.	Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory and speech therapy per member per calendar year.
Surgery	After you pay the deductible, you pay 20% and the Play pays 80%.	After you pay the deductible, you pay 30% and the Play pays 70%.
Urgent Care	\$25 per visit.	After you pay the deductible, you pay 30% and the Play pays 70%.
Well Child Visits	Well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics guidelines.	Well child visits, including immunizations, laboratory and other services ordered at the time of the visit covered in full, according to the American Academy of Pediatrics guidelines.

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Blue PPO Contribution Rates
Calendar Year 2012

Medical Plan	Level of Coverage	Per Pay Period Employee Contribution									
		FULL-TIME SALARY LEVEL 1* Salary < \$37,000		FULL-TIME SALARY LEVEL 2* Salary = \$37,000-77,999		FULL-TIME SALARY LEVEL 3* Salary = \$78,000-116,999		FULL-TIME SALARY LEVEL 4* Salary => \$117,000		EXTENDED PART-TIME ALL SALARIES	
		Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)	Exempt (24 Deductions)	Non-Exempt (26 Deductions)
Blue PPO <i>(those who live outside Rochester area)</i>	Individual	\$31.51	\$29.08	\$48.74	\$44.99	\$57.73	\$53.29	\$66.19	\$61.10	\$92.50	\$85.38
	2 Person	\$74.00	\$68.31	\$103.80	\$95.82	\$117.55	\$108.51	\$132.52	\$122.32	\$202.80	\$187.20
	Family	\$114.25	\$105.46	\$156.80	\$144.74	\$173.77	\$160.40	\$192.46	\$177.65	\$262.64	\$242.43
	One-Parent Fam	\$80.21	\$74.04	\$108.10	\$99.78	\$120.92	\$111.62	\$136.39	\$125.90	\$212.64	\$196.28